Medicaid Nursing Facility Reimbursement Kick-off Meeting

Indiana Family and Social Services Administration

April 29, 2021

Why Reform Indiana's LTSS System?

Choice: Hoosiers want to age at home

- 75% of people over 50 prefer to age in their own home – but only 45% of Hoosiers who qualify for Medicaid are aging at home*
- The risk of contracting COVID and impact of potential isolation drives an even increased desire to avoid institutional settings

Cost: Developing long-term sustainability

- Indiana has about 2% of the U.S. population, but over 3% of nursing facilities
- LTSS members are 4% of Medicaid enrollment, yet 28% of spend - only ~ 19% of LTSS spend goes to home and community-based services (HCBS)
- For next ten years, population projections show 28% increase in Hoosiers age 65+ and 45% increase in Hoosiers age 75+

Quality: Hoosiers deserve the best care

- AARP's LTSS Scorecard ranked Indiana 44th in the nation
- LTSS is uncoordinated and lacks cultural competency
- Payment for LTSS services is poorly linked to quality measures and not linked to outcomes

From 2010 to 2030 the proportion of Hoosiers over 65 will grow from 13% to 20%. Indiana's disjointed system must be reformed to meet growing demand and to ensure Choice, drive Quality and manage Cost.

Indiana's Path to Long-term Services and Supports Reform

Our Objective

1) 75% of new LTSS members will live and receive services in a home and community-based setting
2) 50% of LTSS spend will be on home- and community-based services

Key Results (KR*) to Reform LTSS

1. Ensure Hoosiers have access to home- and community-based services within 72 hours
2. Move LTSS into a managed model
3. Link provider payments to member outcomes (value-based purchasing)
4. Create an integrated LTSS data system linking individuals, providers, facilities, and the state

Agenda

- Project Background
  - Milliman Team - Introductions
  - FSSA Reimbursement Goals and Benefits to Stakeholders
  - Overview of program and workstreams
- Project Methodology
  - General approach
  - Potential evaluation criteria
  - Individual workstreams
- Stakeholder engagement
- Timelines
- Next Steps

FSSA Reimbursement Goals

To develop NF rate setting methods that comply with Centers for Medicare and Medicaid Services (CMS) rules and achieve the following:

- **Alignment** - Bring continuity and alignment across the rate methodologies, providing a consistent framework and supporting payment rates that advance FSSA goals.
- **Sustainability** - Facilitate adequate participant access to quality services, as required by CMS. Cost effective, provide for long-term workforce growth and provider stability, and affordable by the State. Reduce administrative burden. Ensure predictability.
- **Promote Person-Centeredness and Value-Based Purchasing** - Strive to align provider and participant incentives to achieve access to person-centered services, encourage services that drive healthy outcomes and participant satisfaction.
- **Reduce Disparities** – Analyze and quantify disparities in access, quality, site of care, and person-centeredness, then build payment structures to level the playing field.

These goals will be translated into evaluation criteria, to be used for evaluating the current system relative to potential options. Criteria will be established through the stakeholder process.

Benefits to Stakeholders

- All stakeholders
  - New rate methodologies will reflect input from all types of stakeholders including providers, advocates, participants and their families, and others.
  - Rate methodologies will be developed using a transparent process, so all stakeholders can understand how the rates are calculated.
- Individuals and their circle of support
  - May see higher quality and more choice.
  - New methodologies will be designed to support access to services and promote staff retention.
- Provider stakeholders
  - Payment methods will promote payment equity and predictability.
  - Rates will be based on a sound methodology that recognizes the resource requirements of higher acuity patients.
  - New methodologies will seek opportunities to reduce administrative burden of the cost reporting process.

Introduction to the Milliman team

- Christine Mytelka, Milliman
- Jim Pettersson, Milliman
- Ben Mori, Milliman
- Anne Jacobs, Milliman
- Jessica Bertolo, Milliman

Medicaid Nursing Facility Programs Included in Reimbursement Projects

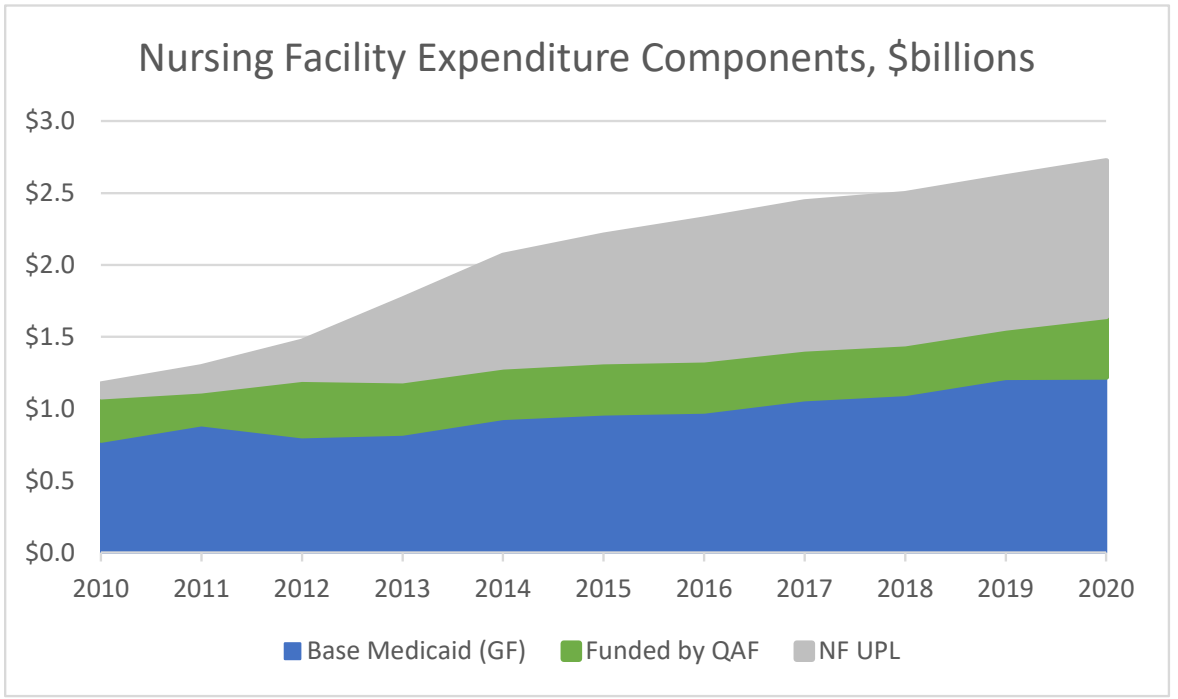
Nursing Facility Reimbursement components

- **Base per diem** reimbursement
- **Value Based Purchasing (VBP) program**, funded by the Quality Assessment Fee (QAF)
- **Nursing Facility Upper Payment Limit (NF UPL) program**, funded by Intergovernmental Transfers (IGTs)

The base per diem and UPL components will each have a separate workstream. In addition, there will be a quality and VBP workstream.

SFY 2020 Highlights

- Total of $2.7 billion in Medicaid NF expenditures
- Served 25,600 average monthly recipients, or 28,500 average monthly enrollees



Expenditures are Medicaid payments only, excluding patient pay and Medicare payments

Workstreams

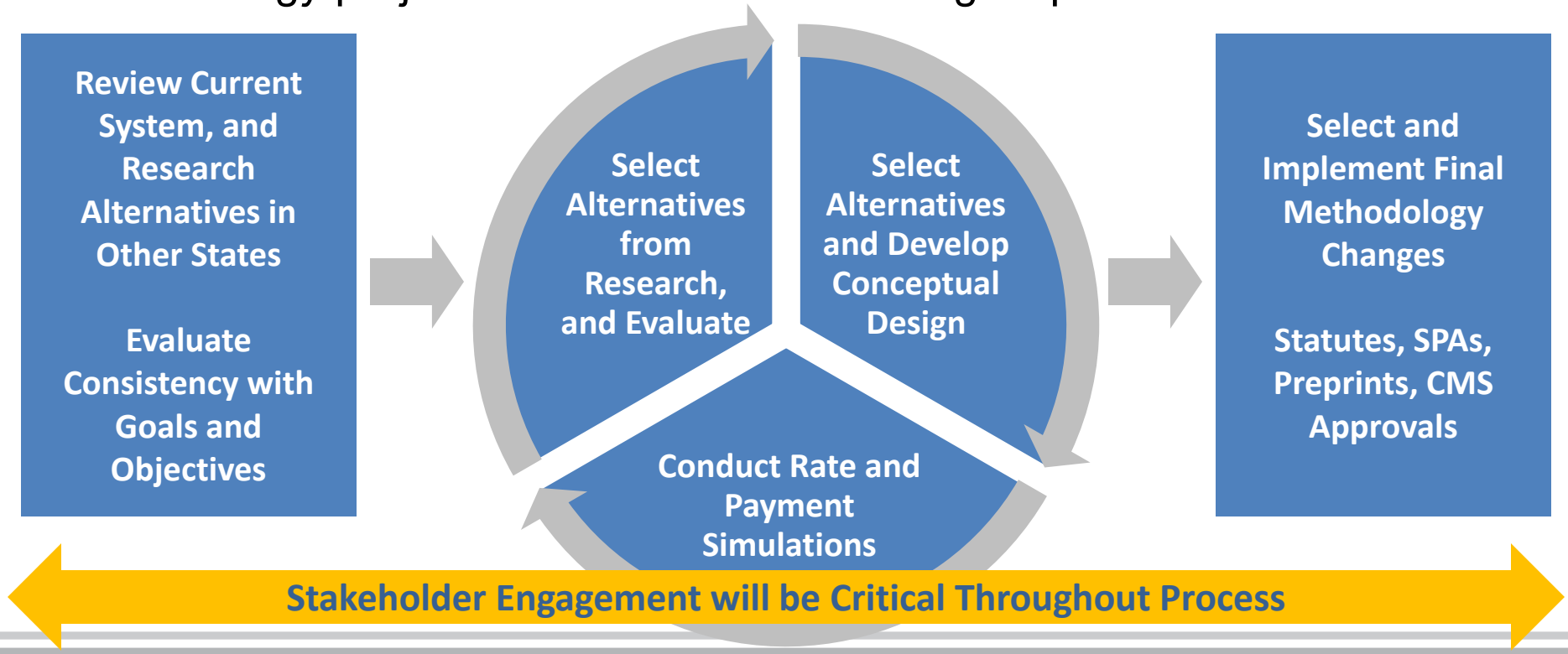
1) Nursing Facility Base Rates
2) Nursing Facility Supplemental (UPL) Program
3) Nursing Facility Quality/Value Based Purchasing

Project Methodology

Project Approach

Overall Project Approach

- FSSA has engaged Milliman to perform research and analysis to evaluate current methodologies relative to alternatives, offer options for consideration, then assist with redesign
- Rate methodology projects will involve the following steps:



NF Reimbursement Evaluation Criteria

Potential Evaluation Criteria

Rate setting methods may be evaluated against the following potential objectives, or *evaluation criteria*, which will be modified and updated as part of the stakeholder process:

1. **Access** - Promote beneficiary access to care, from a range of providers, in consideration of socioeconomic or geographic barriers to care.
2. **Quality** – Promote the delivery of high quality care for all individuals. Build infrastructure and payment supports that enhance and sustain quality and person-centered planning.
3. **Efficiency** - Promote provider economy, efficiency, and good stewardship of federal and local funds that support the program.
4. **Payment equity** – Provide for payments that are equitable and rational. Recognize reasonable and measurable differences in intensity or cost of services. Provide for wages commensurate with skills and experience across all settings.
5. **Alignment** – Provide for alignment and consistency with other programs.

NF Reimbursement Evaluation Criteria

Potential Evaluation Criteria (continued)

6. **Transparency** – Promote understanding of exactly what service or value is being purchased, and how related payments are determined. Facilitate oversight of fund flow.
7. **Reduce disparities**– Analyze and quantify disparities in access, quality, site of care, and person-centeredness, then build payment structures to level the playing field.
8. **Simplicity**– Reduce cost and administrative burden of current system, while maintaining only the complexity necessary to advance payment equity, quality, and other goals.
9. **Predictability**– Promote a clear understanding of the payment structure and how future updates will occur is a fundamental support for long-term planning and workforce development.
10. **Forward Compatibility** – Rate setting Method must be compatible with transition to managed care environment.

Workstream 1: NF Base Rates

- **Key focus of this workstream:**
  - Rate components – cost elements, CMI adjustments, ceilings, other parameters
  - Rate adequacy, including components funded by the QAF and other current funding streams
  - Potential for standardization of rates (with appropriate adjustments applied, e.g., CMI)
  - Fair rental value system elements and methods used to adjust, frequency of updates
  - Quality incentive adjustments, overall size relative the rates, quality metrics
  - Frequency of rate updates, and frequency of rebasing to a new cost basis
  - Application of audit processes
- **Key questions to be addressed:**
  - Should the rate setting methodology be simplified to reduce the administrative burden currently on the providers and State, and in the future on the MCEs, and if so, how?
  - Should the rate setting methodology be modified to create greater incentives for access to quality services, and for appropriate LTSS rebalancing, and if so, how?

Workstream 2: NF Supplemental (UPL) Payments

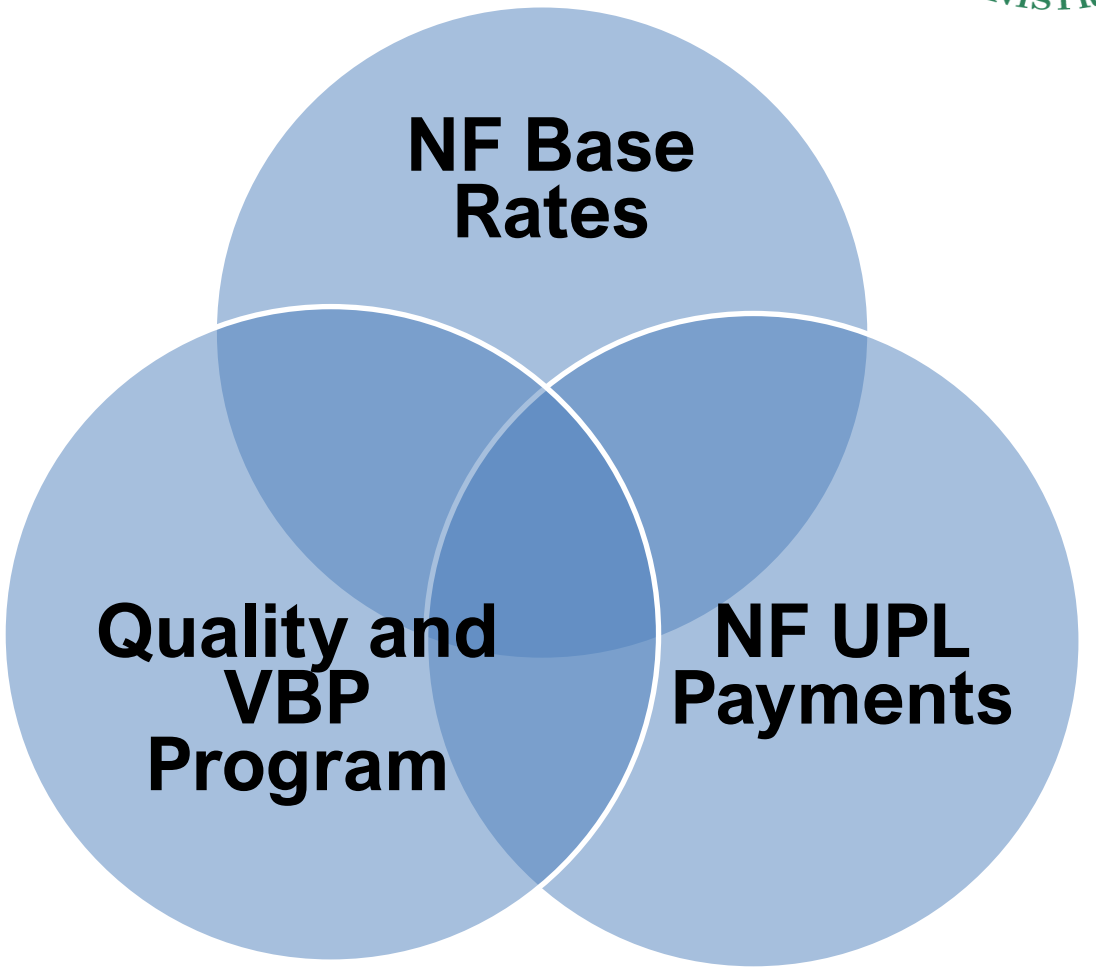
- **Key focus of this workstream:**
  - How program changes may impact nursing facilities and county hospitals
  - Maintaining compliance with federal rules while transitioning to managed care, for both the payment methodology and provider financing
  - Linking payments to quality and other program priorities
  - Relating supplemental payments to base rates in the context of rate adequacy
  - Determining the optimal method for calculating the magnitude and distribution of supplemental payments
- **Key questions to be addressed:**
  - How can supplemental payments be transitioned to managed care using a permissible and sustainable methodology?
  - What future requirements will apply to managed care supplemental payments, and how will providers be impacted?

Workstream 3: Quality and VBP Program

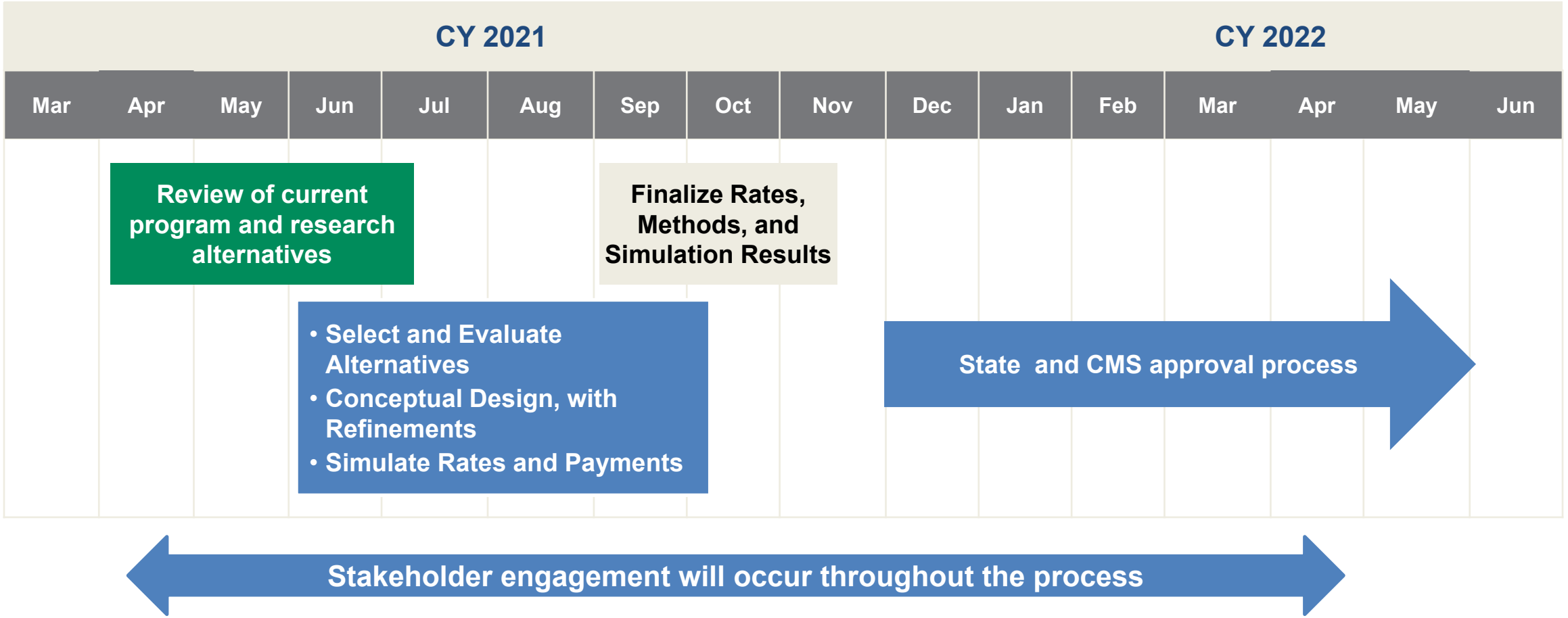
- **Key focus of this workstream:**
  - Identification of FSSA LTSS program performance gaps and priorities
  - Assessment of efficacy of quality incentives currently embedded in the NF rate setting methodology, and historical year-over-year improvements
  - Identification of evidence-based performance measures that can be used to indicate movement consistent with FSSA program priorities, and the prioritization thereof
  - Aligning incentives to reflect and support program-wide LTSS goals
  - Amount of detail to be specified in code or administrative code
- **Key questions to be answered:**
  - Should current incentive measures be modified to better address program gaps and priorities, and if so, how? How frequently should they be reviewed and updated?
  - Should the relative value or proportion of program funding dedicated to quality incentives be increased? What will happen to unspent funds from the quality pool?
  - How should quality incentives be considered in the transition to a managed care model, and will the program be directed by the State? If so, will FFS and MC be aligned?

Workstream Intersections

Solutions identified for individual workstreams may affect potential solutions for all other workstreams



Nursing Facility Reimbursement – Project Timelines



Stakeholder Engagement

Stakeholder Process

- Balanced input from the full range of stakeholders is critical to this process.
- FSSA wants to hear from a variety of stakeholders, including providers and associations, direct service providers, participants and their informal supports, families, advocacy streams, and other key state and federal government stakeholders.
- Stakeholder engagement will include multiple modes of communication, such as:
  - In-person meetings (when it becomes practical)
  - Webinars and virtual meetings
  - Project website, FAQs, and email address
- In addition, per federal requirements, prior to any rate method or rate changes there will be an official 30-day public comment period, followed by 30 days for FSSA to review and respond to public comment. CMS then has a 90 day approval process (which may be extended).

Next Steps

Next Steps

- Workstream meetings to be held on Thursdays
- Each workstream will meet once per month
- Meeting topics and agendas to be developed and sent five business days in advance of the Workstream meetings.
- Please select which of the three workstreams you'd like to attend and indicate your selections to backhome.Indiana@fssa.in.gov . You have the option to attend none, one, two, or all three.

Questions, suggestions?

Submit them via email to:
backhome.Indiana@fssa.in.gov

…Because we are dedicated to helping Hoosiers live self-sufficient, productive lives of their choosing.

Caveats and Limitations

The services provided for this project were performed under the contract between Milliman and FSSA approved May 14, 2010, and last amended December 4, 2020.

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Guidelines issued by the Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. Christine Mytelka is a member of the American Academy of Actuaries and meets the qualification standards for performing the analyses in this report.

The work for this project is still on-going. FSSA has not made any final decisions. FSSA policy decisions, which have yet to be determined, will be subject to state legislative and federal approval.